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GUEST HOME ESTATES IV	1910 E CENTENNIAL STREET PITTSBURG, KS 66762

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S 000	INITIAL COMMENTS The following citations represent the findings of resurvey with complaint #109574 at the above named facility on 12-19-16, 12-20-16, 12-21-16, 12-22-16, 12-27-16, 12-28-16 and 12-29-16.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility identified a census of 22 residents. The sample included 3 residents. Based on record review, interview, and observations for 2 (#333 and #444) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) that meet the needs of each resident and are in accordance with the Functional Capacity Screen (FCS) and the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #333 revealed an admit date of 8-14-15 with diagnoses of lung cancer (10-26-16), adrenal gland cancer,	S3155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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dementia, anxiety, depression, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, degenerative disc disease, diabetic neuropathy, insulin dependent diabetic (new 12-12-16 after chemotherapy started), fibromyalgia, and hypertension.

The FCS dated 8-4-15 recorded resident required supervision with eating, toileting, transfer, and scored 0 for cognition (no short-term memory loss, memory recall, long-term memory loss, impaired decision making), required physical assistance with bathing, dressing, walking/mobility, experienced poor vision and hearing.

The NSA/HCS dated 8-4-15 recorded resident required supervision for toileting, transferring, physical assistance with bathing, dressing, mobility-propels self in wheel chair, staff will provide stand by assist with long distance, no cognitive issues, poor eye sight and hard of hearing.

The NSA/HCS lacked documentation that resident experienced impaired decision making or inappropriate behaviors.

The FCS dated 8-4-16 recorded resident now required physical assistance with toileting, and transfer.

The NSA/HCS dated 8-4-16 recorded monitor and assist as needed with eating, staff will set up, adjust water, assist in and out of shower, assist with washing as requested, assist with drying and redressing if needed two times a week on day shift per resident choice. Staff assist resident with transferring upon request. Resident experienced impaired decision making, impaired

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vision, hard of hearing and family will assist with decisions. Staff will store, reorder, set up and administer medications. Management of behavioral symptoms recorded, "resident manipulates staff, has increased complaint of wanting staff to do things when resident is capable of doing for self."

Note to medical care provider dated 1-12-16 recorded, " resident is displaying more signs of depression since death of family member and had increased need for pain medications. The depression is coming out with behaviors also. Resident wants to be dependent and have the staff wait on him/her. Resident is very vocal to everyone. Resident stated he/she is not worthy of living and going to die a slow painful death. Resident has now isolated self to a table in the dining room to be apart from the other residents and does not attend any activities. Resident is not eating properly and will not eat anything on plate but dessert and then ask for more dessert. Someone from mental behavior unit has set up someone to come tomorrow to screen resident. " Signed licensed nurse A.

The NSA/HCS lacked interventions to address change in behaviors.

The nursing notes recorded the following:

10-26-16 at 3:45 p.m. returned from oncologist office and family stated resident had stage 4 terminal cancer and to start chemo after he/she gets all teeth removed. Have 5 teeth that need to be removed and will start chemo 10 to 14 days after they are pulled. Licensed nurse A.

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S3155	Continued From page 3 10-27-16 1:10 p.m. out to dentist office to have 5 jaw teeth extracted. Resident returned and tolerated procedure well. Licensed nurse A. The NSA/HCS lacked interventions for care and services to be provided after 5 jaw teeth extracted. 11-14-16 at 12:00 noon, Resident to dining room for lunch at 10:50 a.m. and noted to be crying and shaking stating something is wrong, " I don ' t know what it is but it ' s something, " noted to have spilled pitcher of water on floor in room and had large amount of urine on bed. A total bed change done. Oxygen on top of head and was adjusted to be in nose. . . . Resident continued to cry and shake at intervals throughout meal. . . At 3:00 p.m. resident was on call light and stated , " I can ' t, I can ' t " , when asked what can ' t do stated, " Can ' t stand up and go to the bathroom, incontinent of urine and can ' t do it. . . . Requested this nurse to call family and let them know he/she is having difficulty. Doctor called at 1:30 p.m. to report increased anxiety. Chemotherapy to start in morning. . . Resident continued to be tearful with other resident and at times disruptive. Visited with resident that he/she needs to be less emotional in the dining room that other residents are getting upset with about her illness and crying. Licensed nurse A. The NSA/HCS lacked interventions to address resident ' s behavior. 11-23-16 at 1:05 p.m. Returned to facility per this nurse, old port on left upper chest removed and new port placed to upper right chest. No sutures or staples placed, report that wound cement was used. Instructed to leave covered for 48 hours. Licensed nurse A.	S3155		

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S3155	Continued From page 4 The NSA/HCS lacked interventions to observe for signs/symptoms infection, bleeding, pain related to the port placement and lacked information/interventions for signs/symptoms infections or reactions from chemo therapy. Interview and observation on 12-20-16 at 2:40 p.m. with resident (#333) resident got up out of bed without difficulty and transferred self from bed to wheelchair then got dressed without assist for an appointment he/she had later today. The resident started crying when talking about past and that he/she was sexually abused as a small child and later got into drugs/alcohol and now has nothing. I asked resident if he/she is going to another place to get chemo therapy and he/she stated yes had recently started chemo therapy and tolerating it well so far. Resident stated he/she is now a diabetic but is going to eat the foods he/she likes and signed an agreement stating so. The NSA/HCS lacked documentation of diet change or resident refusal of recommended diet. Interview on 12-21-16 at 9:00 a.m. with certified staff G stated resident (#333) has disruptive behaviors but can redirect resident. Resident has days when he/she thinks he/she can ' t get out of bed, stand, or do activities of daily living (ADL ' s). Sometimes resident is ill and needs assistance and sometimes the resident will do things for attention and during showers at times it may 45 minutes because he/she wants different things done. I explain to resident that other residents need showers to and then he/she will cooperate with completing task. At times resident can be rude to staff and then later he/she will apologize. Certified staff G stated and confirmed nothing	S3155		

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documented in care plan for care and services to be provided for inappropriate behaviors, interventions or signs/symptoms for port, chemo therapy, reactions to chemo therapy, and disruptive behaviors.

Interview on 12-21-16 at 10:00 a.m. with licensed nurse A stated " the operator and I have had many meetings with resident #333 and family member about disruptive behaviors and being mean to staff and other residents. " When they have the meetings with resident he/she becomes compliant and in a good mood with staff and other residents. This will last for a while and then resident repeats same behaviors. Resident is getting chemo therapy through a port on right side upper chest at a cancer center. The resident knows if he/she becomes a two person transfer he/she will have to be transferred to a long term care facility. The resident is tolerating chemo well at this time and has started seeing a counselor for inappropriate disruptive behaviors and problems from his/her past history. Licensed nurse A confirmed and stated the NSA/HCS lacked interventions for disruptive behaviors, s/s reactions to chemo therapy and what to watch for when returned from getting chemo. The NSA/HCS lacked information about port placed in upper right chest for intravenous chemotherapy.

Interview on 12-21-16 at 10:30 a.m. with operator stated he/she was aware of resident ' s past from previous occupation. Resident is disruptive and has inappropriate behaviors where he/she will yell, curse, and cry, purposely have incontinent behaviors. The nurse and I have met several times with resident and family member to discuss problems resident exhibited and concerns. The resident will become better after meetings and be

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S3155	Continued From page 6 in a good mood, visit with staff and other residents. Then will start repeating the behaviors again. The operator stated and confirmed the NSA/HCS lacked interventions for inappropriate behaviors, chemo therapy, port for intravenous therapy. For resident #333, the operator failed to ensure the licensed nurse provided and coordinated health care services to meet the needs of the resident . - Record review for resident #444 revealed an admit date of 1-23-16 with diagnoses of dementia, hypertension, macular degeneration, arteriosclerotic heart disease, 12-15-16 stage IV decubitus ulcer to right hip, and stage II pressure ulcer to lower bony prominence of back. The FCS dated 1-23-16 recorded resident independent with toileting, transfer, walking/mobility, eating, required physical assistance with bathing, dressing, experienced short-memory loss, impaired memory recall, impaired decision making, and used no mobility devices. Nurses notes document resident found on floor on 2-27-16, complained of pain to the lower back and was hospitalized until 3-1-16. Record lacked documentation of revision of the negotiated service agreement/health care service plan (NSA/HSC) upon return from the hospital. Nurses notes from 3-1-16 to 3-3-16 document resident continued to complain of pain, physical therapy initiated and placed a binder on the resident for support.	S3155		

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S3155	Continued From page 7 The FCS amended on 3-4-16 recorded resident #444 now required physical assist with toileting, walking/mobility, transfer, and used a walker and wheelchair for mobility. The NSA/HCS dated 1-23-16 and amended on 3-4-16 recorded staff will set up and assist resident in and out of shower, cue and assist resident to restroom every two to four hours, staff will perform incontinent care, monitor when in halls, assist with dressing and TED hose on in am and of at bedtime, staff to assist up from chair as needed. The NSA/HCS lacked interventions related to the use of assistive devices for mobility and lacked instructions for use of the binder. Nurses notes 4-26-16 at 2:00 p.m. recorded Doctor office notified of increased excoriation to buttock with small open areas. Licensed nurse A. Nurses notes document resident continued to experience back pain, was diagnosed with compression fracture to the mid back with nerve issues and was hospitalized. The record lacked documentation on the date and time the resident left the facility for the hospital. Nurses note 5-17-16 at 4:50 p.m. Resident arrived from hospital with family member. Thoracic brace in place. Resident able to ambulate with walker fifteen feet. Order to change hydrocodone/APAP to 5/325 milligrams every six hours as needed for pain. To have x-ray prior to follow up appointment. Physical therapy ordered for gait training, balance, and strengthening. Will start in am. Licensed nurse A.	S3155		

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S3155	Continued From page 8 Documentation lacked skin assessment and documentation of presence of wound with dressing NSA/HCS amended on 5-17-16 to include thoracic back brace on when up, wheel chair until stronger, stand by assist with all transfers and ambulation. NSA/HCS lacked description of services related to management of wound Nurses notes documented 5-19-16 at 2:00 a.m. Resident had pulled dressing off of wound on right buttock. Calmo lotion applied. Continue to monitor. Certified staff F. Record lacked documentation of assessment of wound by licensed nurse and the NSA/HCS continued to lack inventions related to management of the wound. Nurses note 6-7-16 at 10:00 a.m. called to room by staff and upon entering room found resident lying on floor on back. Nurse notified range of motion done and resident complained of pain in right leg. Nurse instructed to send to hospital by ambulance. 10:35 a.m. resident sent to hospital. Certified staff D. 6-21-16 at 2:40 p.m. Resident returned to facility per care van from hospital after total hip replacement. Back brace in place. Resident stood for transfer with gait belt and noted to have increased difficulty with pain and weakness to right leg. Physical therapy here to stand resident up. Family reported resident in bed most of the	S3155		

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time while in the hospital. Right hip noted to have ten inch healing incision with several steri strips in place with some purple discoloration areas to bottom. Resident bottom has some redness with no open areas. Staff educated to use bedside commode at night. New orders for hydrocodone and fentanyl patches. Licensed nurse A.

The significant change FCS dated 6-21-16 recorded resident independent with eating, required physical assistance with bathing, toileting, mobility, walking standby assist with all ambulation with gait belt. Staff will ensure resident is 45 degrees or higher. Abdominal support will be put over brace. Gait belt will be used with all transfers/ambulation.

Nurses note 10-24-16 at 4:50 p.m. Noted to have a three centimeter (CM) stage three necrotic tissue to lower buttock right side. Doctor notified for treatment order and received. Licensed nurse A.

The NSA/HCS lacked interventions to address management of wound and interventions to prevent further skin breakdown

Nurses note 11-2-16 at 4:00 p.m. Wound dressing done. Noted 2 CM by 2.5 CM with edges pink and large necrotic tissue in center of wound. Difficult to measure depth possible .8 CM deep. Doctor notified of need to debride wound. Will return call. Licensed nurse A.

11-8-16 at 1:45 p.m. Area to right hip debrided. Antibiotic ordered, area cultured. New treatment order received. Licensed nurse A.

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S3155	Continued From page 10 The NSA/HCS continued to lack interventions to address management of the wound and interentions to prevent further skin breakdown. Nurses notes document wound care treatments at wound clinic with need for vancomycin (antibiotic) intravenous to treat wound infection. Nurses notes further document residents sent to day surgery on 11-28-16 for placement of peripheral inserted central catheter (PICC) line for administration of antibiotic by home health. The NSA/HCS lacked interventions to address management of PICC line. Nurses notes on 11-29-16 at 10:45 a.m. Certified staff F called this nurse at 6:15 a.m. to report he/she assisted resident to restroom at 3:10 a.m. and PICC line was in place and at 5:00 a.m. he/she checked on resident and it was lying on bed with all dressings next to resident on bed. Staff checked arm and clothing with no visible bleeding seen. Clothing was on resident. Family and wound care notified of resident pulling out PICC line. Licensed nurse A. 11-29-16 at 3:05 p.m. Family here to admit resident to hospital for intravenous antibiotic therapy. Licensed nurse A. 12-8-16 at 5:30 p.m. Resident arrived to facility per private auto accompanied by family. . . Licensed nurse A. Documentation lacked skin assessment and description of wound,	S3155		

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S3155	Continued From page 11 NSA/HCS lacked interventions to address management of wound. 12-9-16 at 11:00 p.m. Resident had already stripped off pants, socks, brief, and dressing to wound. Toileted resident and re-dressed for bed. Recovered wound. Instructed resident about call light and leaving dressing alone. Will continue to monitor. Certified staff F. 12-10-16 at 2:00 p.m. Treatment done as ordered. No complaints or discomfort. Certified staff D. 12-16-16 at 2:00 p.m. Treatment done to area on right hip. This nurse and certified staff D completed treatment with mesalt (absorbent dressing to promote wound healing). Area 1.8 CM in diameter and approximately 2 CM deep, loosely packed with mesalt and covered with meplex lite (foam dressing). Licensed nurse A. On 12-21-16 at 11:20 a.m. observed certified staff F ambulate resident #444 with back brace on and use of gait belt in hallway to dining room chair. Interview on 12-21-16 at 11:35 a.m. with certified staff F stated they have not used the abdominal support wrap around brace in a long time. On 12-21-16 at 12:45 p.m., observed licensed nurse A change dressing to right hip on resident #444. Observed serosanguineous drainage. Wound clean approximately 2 CM in circumference and 2 CM deep tunneling. Wound cleansed with normal saline, packed with mesalt, and covered with mefix dressing. Wound to lower bony prominence at lower back approximately 1.2 CM pink area healing cleansed	S3155		

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S3155	Continued From page 12 with normal saline and covered with mefix dressing for protection. Noted the bed lacked a pressure relieving device on mattress. Resident can turn self and was lying on left side. Resident stated he/she gets up by self and licensed nurse A reminded resident he/she must call for assistance to get up. Resident stated he/she would. Interview on 12-21-16 at 3:50 p.m. with operator and licensed nurse A stated resident used to have an abdominal wrap around brace to keep from removing brace and noted HCS stated abdominal wrap to be on over brace when up. Licensed nurse A stated and confirmed resident developed a stage IV pressure ulcer with necrotic tissue on right buttock at the facility. The wound was identified to have MRSA at the wound clinic and did not have the results of the culture but was given information verbally. Licensed nurse A confirmed the NSA/HCS lacked interventions for pressure ulcer, infection control for MRSA, pressure relieving device on bed for resident, frequent monitoring for PICC line with potential for bleeding. For resident #444, the operator failed to ensure the licensed nurse provided or coordinate the necessary health care services to meet the needs of the resident.	S3155		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.	S3171		

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S3171	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility identified a census of 22 residents. The sample included 3 residents. Based on record review, interview, and observations for 1 (#333) of 3 residents sampled, the operator failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice when the resident exhibited signs and symptoms of respiratory distress and the nurse failed to assess and intervene to ensure the resident received appropriate medical follow up. Findings included: - Record review for resident #333 revealed an admit date of 8-14-15 with diagnoses of lung cancer (10-26-16), adrenal gland cancer, dementia, anxiety, depression, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, degenerative disc disease, diabetic neuropathy, insulin dependent diabetic (new 12-12-16 after chemotherapy started), fibromyalgia, and hypertension. The FCS dated 8-4-15 recorded resident required supervision with eating, toileting, transfer, and scored 0 for cognition (no short-term memory loss, memory recall, long-term memory loss, impaired decision making), required physical assistance with bathing, dressing, walking/mobility, experienced poor vision and hearing. The NSA/HCS dated 8-4-15 recorded resident required supervision for toileting, transferring, physical assistance with bathing, dressing,	S3171		

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S3171	Continued From page 14 mobility-propels self in wheel chair, staff will provide stand by assist with long distance, no cognitive issues, poor eye sight and hard of hearing. The NSA/HCS lacked documentation that resident experienced impaired decision making or inappropriate behaviors. The nursing notes recorded the following: 6-6-16 at 10:30 a.m., " Upon this nurse ' s arrival resident complained of not feeling well stating ' I can ' t breathe ' . Resident does not appear to be in distress oxygen saturation 95% on room air. Lungs auscultated and noted to have crackles with occasional wheezing. . . . Signed licensed nurse A. 6-8-16 at 11:00 a.m., Resident continued to complain of difficulty breathing. Dr. Office notified of complaints and stated next stop is pulmonary clinic and they will check into this and call back. Signed licensed nurse A. 6-8-16 at 6:00 p.m., " Certified staff reports resident asked to be sent to the hospital after this nurse leaves. Family called and updated that resident wanting to go to emergency room. Oxygen saturations in mid-90 ' s. No outward symptoms of distress, any blanching, any gasping, and resident appeared to breathe per usual. Family agrees if no symptoms of distress not need to go to emergency room. Resident placed on seventy two hour watch to be monitored more closely. Continue to await call from doctor. " Signed licensed nurse A.	S3171		

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S3171	Continued From page 15 Documentation lacked assessment of lung sounds or further attempts to notify the doctor of the resident ' s continued complaint of difficulty breathing. 6-8-16 at 7:00 p.m. vital signs taken temperature (T), 98.7, pulse (P) 75, blood pressure (B/P) 125/67 and oxygen saturation 95% room air. . . . Resident had albuterol (breathing treatment) at 3:00 p.m. and 7:00 p.m. Certified staff E. 6-9-16 at 3:15 p.m., resident complained of short of air during evening meal. Oxygen placed on at 2 liters/min by nasal cannula. Reports it helped. Licensed nurse A. 6-9-16 at 9:30 p.m. resident ambulated to dinner in wheel chair and was sort of breath so we brought in oxygen. Breathing treatment given every four hours and says not feeling better. B/P 122/69, P 79, R 16, oxygen saturation 92%. Signed Certified staff C. 6-10-16 at 2:00 p.m. To dining room for both meals per wheel chair. Oxygen saturation on room air 85% with oxygen on 92%. Has complained of pain and shortness of breath. Hydrocodone given two times today for pain. Resident in bed at present time and stated felt a little better. Certified staff D. 6-11-16 at 1:00 p.m. Resident refused to come down for breakfast and did come for lunch. Had two breathing treatments today. Complained of pain all over earlier. Remains on oxygen. Oxygen saturation 85% on room air and 92% with oxygen. Signed certified staff D.	S3171		

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S3171	Continued From page 16	S3171		

6-11-16 at 9:00 p.m. Resident ate 50 % meal in dining room. Oxygen on resident while in room. Oxygen saturation 95%. Breathing treatments at 4:30 p.m. and 8:30 p.m. Resident complained of lower back pain and will continue to monitor. Certified staff E.

6-13-16 at 3:10 p.m. ,Resident asked this nurse to call doctor ' s office for appointment. This nurse call and appointment scheduled for 6/28/16 at 11:15 a.m. When resident told of appointment he/she stated what they are going to do about this pointing to lung. Explained when appointment was requested this nurse requested for colonoscopy result and to talk about lungs. Resident stated, " Well that is too far off and I need to go in sooner ...you are just going to let me die! " . . . Resident requested nurse call family to schedule appointment. Licensed nurse A.

6-14-16 at 9:30 p.m. . . . Resident complained of nausea and stated unable to pull up brief by self anymore. . . . Certified staff E.

Record lacked assessment of resident ' s respiratory status by licensed nurse for 6 days and lacked documentation of assessment of pain reported by resident on 6/10/16 and 6/11/16.

6-16-16 at 11:10 a.m. staff called this nurse to report oxygen saturation was 80% and oxygen was on. Instructed to turn oxygen up to 5 liters/min. and call 911. Family was at bedside. Certified staff E.

6-16-16 at 2:30 p.m. This nurse notified resident admitted to hospital for pneumonia and urinary

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S3171	Continued From page 17 tract infection. 6-23-16 at 2:30 p.m. resident returned to facility. . . .. On continuous oxygen at two liters via nasal cannula. Certified staff E. 6-25-16 at 8:00 p.m. complained of pain all over. Call light in reach. Will continue to monitor. Certified staff B Record lacked documentation nurse notified of resident ' s complaint of pain and lacked documentation of a nursing assessment upon return to the facility following hospitalization. 6-27-16 at 6:30 a.m. Vital signs taken at 3:45 a.m. T. 97.6, B/P 155/102, P 96, R. 20, oxygen saturation 89%. No complaint of pain. Resident asked if certified staff knew resident had been gone for the last four days. Certified staff stated he/she worked and resident was here at facility. Resident stated , " Well I was here but I wasn ' t ' here ' . " Resident very needy throughout the night. Call light in reach. Certified staff F. Record lacked documentation nurse notified of elevated pulse and blood pressure and decrease oxygen saturation and lacked follow up assessment by the nurse. 6-27-16 at 9:30 p.m. Resident had repetitive health complaints. Resident complained of pain in right rib area and hallucinating seeing a woman. . . Resident tearful and crying when expected to perform toileting and dressing tasks but was able to complete stand by assist. Hydrocodone (for pain) and breathing treatment given at 7:30 p.m. Certified staff G.	S3171		

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S3171	Continued From page 18 Record lacked documentation of assessment of resident by licensed nurse for continued complaint of pain and change in mental status. 9-27-16 at 10:00 a.m. Resident had a temperature of 101.8 this am and oxygen saturation 80%. Tylenol and hydrocodone given for temperature at this time. Resident wants to go to emergency room after lunch. Medical care provider notified. At 5:00 p.m. medical care provider called and ordered a portable chest x-ray in am. Licensed nurse A. 9-30-16 at 1:30 a.m. T. 98.1, P 71, R 20, oxygen saturation 85%, BP 160/76. Resident asked for pain medication. Certified staff F. 10-1-16 at 1:15 p.m. Complained of pain and shortness of breath. Pain medication and breathing treatment administered. Will continue to monitor. Certified staff F. Resident experienced change in condition with increased temperature, decreased oxygen saturation and complaints of pain and shortness of breath. The record lacked documentation that they licensed nurse was notified of the change in condition and lacked documentation of an assessment by the nurse. Interview and observation on 12-20-16 at 2:40 p.m. with resident (#333) stated she had a port placed to right side of upper chest and identified area that is healed. Resident then got up out of bed without difficulty and transferred self from bed to wheelchair then got dressed without assist for an appointment he/she had later today. Surveyor asked resident if he/she is going to	S3171		

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S3171	Continued From page 19 another place to get chemo therapy and he/she stated yes had recently started chemo therapy and tolerating it well so far Resident stated he/she is now a diabetic but is going to eat the foods he/she likes and signed an agreement stating so. For resident #1 (#333), the operator failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice when the resident exhibited signs and symptoms of respiratory distress, change in condition and complaints of pain and the nurse failed to assess and intervene to ensure the resident received appropriate medical follow up.	S3171		
S3201 SS=F	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.	S3201		

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S3201	Continued From page 20 This REQUIREMENT is not met as evidenced by: KAR-26-205(d)(3)(D) The facility identified a census of 22 residents. The sample included 3 residents. Based on record review, interview, and observations for all residents, the operator failed to ensure the licensed nurse or Certified Medication Aide (CMA) documented the administration of each resident's medication immediately before or following completion of the task. Findings included: - Interview on 12-19-16 at 3:35 p.m. with licensed nurse A stated the CMA's pre-set medications in trays one hour prior to time medications due. They use the OPUS system with medication cassettes and have to snap open each individual medication in each cassette. The CMA's do not set up medications for the entire shift. On 12-19-16 at 4:15 p.m. tour of medication room with licensed nurse A revealed a medication tray set up with 5:00 p.m. medications for thirteen residents. A second tray revealed medications set up with 8:00 p.m. medications for twenty residents. Licensed nurse A stated, "they are not supposed to set up 8:00 p.m. medications until 7:00 p.m." Review of the MAR (medication administration record) documented 5 p.m. and 8 p.m. medication initiated as given. Licensed nurse stated and confirmed medications preset and initialed as administered in the MAR as given at 8:00 p.m. at 4:15 p.m.	S3201		

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S3201	Continued From page 21 Interview 12-19-16 at approximately 4:20 p.m. with CMA C stated he/she preset up medications for 5:00 and 8:00 p.m. and had initialed the MAR for the medications due 5:00 p.m. and 8:00 p.m. when he/she set the medications up in the tray. For all residents, the operator failed to ensure the licensed nurse or CMA documented the administration of each resident's medication immediately before or following completion of the task.	S3201		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;	S3305		

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S3305	Continued From page 22 (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-207(a) The facility identifed a census of 22 residents. The sample included 3 residents. Based on interview and observations for all residents, the operator failed to ensure the provision of a safe, sanitary, and comfortable enviornment for residents. Findings included: - Tour of facility kitchen on 12-19-16 at 3:55 p.m. revealed mouse droppings through out area under kitchen sink. Kitchen staff C stated that area should be cleaned daily as cleaning suppliles are under the sink and someone should of seen the mouse dropppings. Licensed nurse A stated pest control was here last week. On 12-20-16 at 1:25 p.m. operator provided a copy of pest control visit dated 12-12-16 for rodents in kitchen area. For all residents, the operator failed to monitor and ensure the provision of a safe, sanitary, and	S3305		

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S3305	Continued From page 23 comfortable enviornment for residents.	S3305		